EXHIBIT 2

Facility Name:_____

Facility Tax ID:_____

Certification Statement Unwanted Pharmaceuticals Disposal
CERTIFICATION STATEMENT

The Chief Operations Executive or Owner is responsible for the preparation and completion of the questionnaire and must read and sign the Certification Statement listed below.

Check Certification Statement #1 if the facility purchased, borrowed, dispensed, distributed, and/or administered pharmaceuticals during the 2008 calendar year and the facility has completed the questionnaire.

Check Certification Statement #2 if the facility did not purchase, borrow, dispense, distribute and/r administer pharmaceuticals during the 2008 calendar year.

Sign the bottom of this Certification Statement page after checking the appropriate certification statement.

☐ **Certification Statement #1**

I certify under penalty of law that the attached questionnaire was prepared under my direction or supervision and that qualified personnel properly gathered and evaluated the information submitted. The information submitted is, to the best of my knowledge and belief, accurate and complete. In those cases where we did not possess the requested information for questions applicable to our company, we provided best estimates. We have to the best of our ability indicated what we believe to be company confidential business information as defined under 40 CFR Part 2, Subpart B. We understand that we may be required at a later time to justify our claim in detail with respect to each item claimed confidential. I am aware that there are significant penalties for submitting false information, including the possibility of fines and imprisonment as explained in Section 308 of the Clean Water Act.

☐ **Certification Statement #2**

I certify under penalty of law that this Facility did not purchase, borrow, dispense, distribute and/or administer pharmaceuticals during the 2008 calendar year. I am aware that there are significant penalties for submitting false information, including the possibility of fines and imprisonment as explained in Section 308 of the Clean Water Act.

_____ _____
Signature of CEO or Owner *Date*

_____ (___)_____
Printed Name of CEO or Owner *Telephone # of CEO or Owner*

_____ _____
Pharmacy Director/Manager *Facility Tax ID Number*

_____
Printed Name of Pharmacy Director/Manager

_____
Facility Name

Facility Name:_____
Facility Tax ID:_____

Part A: Health Facility Information

Instructions: Complete Part A of the questionnaire for operations at the Facility in calendar year 2008.

A-1. List the name of the health facility noted on the licensure: _____

A-2. Physical address of health facility
_____Street

_____City _____State _____Zip

A-3 Health Facility CEO/Administrator Contact Information

Name of CEO/President or Administrator of Facility:_____

Telephone Number (___)_____ Email:_____@_____
□ Check here if mailing address is same as above

Address of Network Headquarters
_____Street

_____City _____State _____Zip

A-4 State Licensing the Facility:_____ Licensure Number for Facility:_____

Date of Expiration of Licensure:_____

A-5 What type of Facility do you operate? Check all that apply
□ Hospital
□ Long Term Care Facility (LTCF)
□ Community Based Residential Facility (CBRF)
□ Skilled Nursing Facility (SNF)
□ Intermediate Care Nursing Facility (ICNF)
□ Assisted Living and Independent Living Facilities
□ Hospice Care Center
□ Medical Office Infusion Center
□ Ambulatory Infusion Center
□ Psychiatric and Substance Abuse Facility
□ Veterinary Hospital/Clinic[FM1]
□ Other:_____

Facility Name:_____
Facility Tax ID:_____

A-6 Facility is part of Integrated Health Network? □ Yes □ No *(if no proceed to A-7)*

If yes, Name of Network:_____

□ Check here if mailing address is same as above

Physical address of Network Headquarters
_____Street

_____City _____State _____Zip

Name of CEO or President of Health Network: _____

Health Network CEO or President telephone Number (___)_____
Health Network CEO or President Email: _____

A-7 What is the name, telephone / fax numbers, and email address for the Pharmacy Director/Manager or Medication Service provider for the facility for the information supplied in Part A of this data request?

Name of Pharmacist Director/Manager:_____

Telephone Number (___)_____ Email:_____@_____

State Licensed to Practice Pharmacy: _____Licensure Number: _____

□ Check here if mailing address is same as above
Business address Pharmacist Director/Manager
_____Street

_____City _____State _____Zip

A-8 Demographic Information of the healthcare facility
What is this facility's ownership?
☐ Government
☐ Federal
☐ State
☐ Indian Nation
☐ Community (County, City, Town, etc.)
☐ Private

The facility tax status is:
☐ Not-For-Profit (including religious)
☐ For-Profit (Investor-owned)

How many beds is the health-facility licensed for?_____ □ NA
What is the average number of monthly Admissions/Visits?:_____
What is the average number of monthly Patient/Resident Days?:_____ □ NA

Facility Name:_____

Facility Tax ID:_____

How many months during calendar year 2008 were patients admitted?:_____ ☐ NA

Currently, how many employees (full- and part-time) work at this facility?
Full time equivalents (40+ hours/week) _____ FTEs

What were the 2006, 2007, and 2008 operating costs for this facility? (Round to nearest thousand; the zeros are already in the table.)

2006	2007	2008
$ _ _ _, _ _ _, 0 0 0	$ _ _ _, _ _ _, 0 0 0	$ _ _ _, _ _ _, 0 0 0

For All Facilities
For the facility was the following services provided in 2008?

Oncology or Cancer Care	☐ Yes ☐ No	Vaccinations	☐ Yes ☐ No
Bone marrow transplants	☐ Yes ☐ No	Intravenous antibiotics	☐ Yes ☐ No
Major joint replacement	☐ Yes ☐ No	Pain management	☐ Yes ☐ No

A-9 How were pharmaceuticals provided to the facility in 2008? *Check all that apply.*
☐ On-site pharmacy department through wholesaler
If checked list wholesaler:_____
☐ Contracted outsourced pharmacy service,
If checked outsource company _____
☐ On-Site retail pharmacy department
☐ Other:_____
☐ Other:_____

☐ Contact information for the outsource pharmacy service:

Name: _____

Address: _____

_____

_____

Telephone: _____

Email Address: _____

A-10 Where were pharmaceuticals stored at the Facility upon delivery from the pharmacy to the patient care areas? *Check all that apply.*
☐ Medication Room
☐ Non-automated storage cabinet
☐ Patient servidor or server
☐ Satellite pharmacy
☐ Refrigerator
☐ Automated dispensing cabinet (*e.g.*, Pyxis, Omnicell, etc.)
☐ Other:_____

A-11 What primary software system(s) was used in 2008 for documenting the dispensing and administration of medication?

Facility Name:_____

Facility Tax ID:_____

_____Dispensing _____Administration

What was the facility's average monthly number of medication doses administered to in-patients in 2008: _____ DOSES, OR

What was the facility's average monthly number of medication doses (all forms) billed to in-patients in 2008: _____doses

What were the total drug expenses for 2008 for the facility? $_____

A-12 Does the facility have a formalized written plan in place to dispose of unwanted pharmaceuticals? ☐ Yes ☐ No

A-13 Check the mode(s) of disposing of pharmaceuticals that are unwanted for the following drugs or drug classes. Note disposal can be either on the nursing/living unit or in the pharmacy. *Check all that apply.*

Drug or Drug Class	**Do Not Use**	**Normal Trash**	**Sewer System**	**Biohazard Container *Red Sharps***	**Trace Chemo Container Yellow**	**Non-hazardous Pharm Wase Container**	**EPA RCRA Hazardous Black**	**Reverse Distributor**	**Other, List**
Controlled substances	☐	☐	☐	☐	☐	☐	☐	☐	☐
Injectable oncology	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oral Oncology	☐	☐	☐	☐	☐	☐	☐	☐	☐
Insulin	☐	☐	☐	☐	☐	☐	☐	☐	☐
Warfarin	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used Fentanyl patches	☐	☐	☐	☐	☐	☐	☐	☐	☐
Morphine	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cyclophosphamide	☐	☐	☐	☐	☐	☐	☐	☐	☐
Aspirin	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cefazolin IVPB	☐	☐	☐	☐	☐	☐	☐	☐	☐
Total Parental Nutrition	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mitomycin	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used Nicotine patches	☐	☐	☐	☐	☐	☐	☐	☐	☐
Flu Vaccine vials	☐	☐	☐	☐	☐	☐	☐	☐	☐

A-14 Does the facility utilize a Reverse Distributor to manage unwanted pharmaceuticals?
☐ Yes ☐ No
If Yes, List Company:

Name: _____

Address: _____

_____

_____

Telephone: _____

Email Address: _____

If No, proceed to question A-15

Does the Reverse Distributor remove from the facility partial doses for example unwanted IVs, unwanted syringes, partial oral liquids, etc
□ Yes □ No
If yes, provide 2008 itemized invoices for pharmaceutical processing

A-15 Does the facility have a budget line or account for managing pharmaceutical wastes?
□ Yes □ No
If yes, provide 2008 expenses by category, *i.e.,* hospital staff, reverse distributor, etc. for pharmaceutical waste management $_____

Did the facility in 2008 keep records of all pharmaceuticals disposed of due to doses not used or outdating for the following classes of drugs

Controlled Substances CII	□ Yes	□ No, if yes by □ weight □ doses □ both
Chemotherapy	□ Yes	□ No, if yes by □ weight □ doses □ both
Other RCRA Hazardous Waste	□ Yes	□ No, if yes by □ weight □ doses □ both
Non-hazardous drug wastes	□ Yes	□ No, if yes by □ weight □ doses □ both

If yes to any, please provide 2008 records for estimation purposes only

A-16 If the facility disposed of unwanted pharmaceuticals down a drain or toilet in 2008, please indicate the destination of the waste water from the Facility.

□ Waste water is sent to a sewage treatment plant.
_____
Name of company/utility on your sewer bill (example: City of Springfield Public Works)

□ The facility does not have a sewer bill because the Facility is a direct waste water discharger
_____
Name of river, lake, or surface water
_____
NPDES Permit Number

□ Wastewater is sent to another destination_____
Explain:_____

□ Septic System

□ Unknown

A-17 With regards to flushing unwanted pharmaceuticals down a drain or toilet in 2008, *check all that apply.*

☐ No unwanted Pharmaceuticals Flushed Down the Drain or Toilet
☐ Medicare Policy
☐ Medicaid Policy
☐ Drug Enforcement Administration (DEA) Policy (Controlled Substances Act)
☐ State or Local Policy
☐ Organization and/or Facility Guidelines
☐ Ease of Disposal
☐ Cost of Disposal Alternatives
☐ Staff Time Constraints
☐ Staff and patient safety

☐ Other (specify) _____
☐ Other (specify) _____
☐ Other (specify) _____

A-18 If you checked “Medicare Policy”, “Medicaid Policy”, “DEA Policy”, or “State or Local Policy” in Question A-16, please explain why these policies caused your Facility to dispose of unwanted pharmaceuticals by flushing down the drain or toilet.

☐ Medicare Policy: _____
☐ Medicaid Policy: _____
☐ DEA Policy: _____
☐ State or Local Policy (provide citation to regulation): _____
☐ Organization and/or Facility Guidelines:_____

A-19 What is the basis for your current policy regarding unwanted pharmaceutical disposal? Check all that apply.

☐ Hazardous waste (RCRA) requirements
☐ State requirements
☐ Waste minimization
☐ Practice GreenHealth (f.k.a., H2E) or other green organization
☐ Cost reduction
☐ Drug Enforcement Administration (DEA)
☐ Medicare and/or Medicaid compliance
☐ OSHA compliance
☐ Other (specify): _____

A-20 Compliance and Performance Surveys

Has the facility been visited by the The Joint Commission (TJC) in the past three years?
☐ Yes ☐ No

If yes, was the facility given any Request For Improvements (RFI) for the medication management and or Environment of Care chapters that relate to pharmaceutical waste disposal?
☐ Yes ☐ No, if yes please provide RFIs

Has the facility been visited by the Centers for Medicare and Medicaid Services (CMS) in the past three years?
☐ Yes ☐ No

If yes, was the facility cited for any violations as it pertains to the disposal of medications or chemicals?
☐ Yes ☐ No, If yes please provide a copy of the report

Has the facility been visited by United States Environmental Protection Agency in the past three years?
☐ Yes ☐ No, if yes please provide a copy of the report

Has the facility been visited by the state Environmental Protection Agency in the past three years?
☐ Yes ☐ No, if yes please provide a copy of the report

A-21 For the purpose of training staff in proper pharmaceutical disposal, what is the best type of material the Environmental Protection Agency (EPA) can provide you (i.e., brochure, CD/DVD)? Check all that apply

- ☐ CD
- ☐ DVD
- ☐ Internet downloads of written material
- ☐ Web-based training
- ☐ Hard Copy
- ☐ Outreach meetings
- ☐ Other (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____